COX-2 Inhibitor Prior Authorization Request Form

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through Blanchfield Army Community Hospital Pharmacy or its Clinics.

Your patient receives their prescription drug benefit from the Blanchfield Army Community Hospital Pharmacy. You have prescribed a COX-2 Inhibitor for your patient that requires Prior Authorization before this medication can be provided. **Concurrent with completing a prescription or entering the prescription into CHCS for this patient, please make a copy of this form, complete steps 1 through 3 and give the completed form to the patient. Instruct the patient to bring this completed form to Blanchfield Army Community Hospital Pharmacy for processing. To contact Blanchfield Army Community Hospital Pharmacy, please call 270-798-8074.**

Please designate drug for which Prior Authorization is requested:

- ☐ **Valdecoxib (Bextra®) - preferred**
- ☐ **Rofecoxib (Vioxx®)**
- ☐ **Celecoxib (Celebrex®) – once-daily only**

Step 1 Please complete patient and physician information (Please Print)

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

SSN #: _____ Phone #: _____

Date of Birth: Beeper/Fax #:

Step 2 Please complete the clinical assessment

1. **How old is the patient?**
   - ☐ Less than 65 years of age. Please proceed to Question 2
   - ☐ 65 years of age or older. Benefit is approved for 1 year. (Note: It is not necessary to submit a prior authorization form for patients who are 65 or older. COX-2 inhibitor prescriptions for patients 65 years or older will be automatically approved based on the age in their CHCS patient profile. If you are uncertain about the patient's age, please proceed to Question 2.)
2. **Is this drug being prescribed for treatment of familial adenomatous polyposis?** ☐ Yes ☐ No
   If yes, benefit is approved for up to 1 year.
   If no, proceed to Question 3.
3. **Is this drug being prescribed for the prevention or treatment of colon cancer or Alzheimer's disease?** ☐ Yes ☐ No
   If yes, benefit coverage is not approved.
   If no, proceed to Question 4.
4. **Will this patient receive Celebrex, Vioxx, or Bextra concurrently with another NSAID (non-steroidal anti-inflammatory drug), or with aspirin at a dose greater than 325 mg per day?** ☐ Yes ☐ No
   If yes, benefit coverage is not approved.
   If no, proceed to Question 5.
5. **Does this patient have a history of peptic ulcer disease, NSAID-related ulcer, clinically significant gastrointestinal bleeding, or an inherited or acquired coagulation defect (e.g., hemophilia, chronic hepatic failure)?** ☐ Yes ☐ No
6. **Has this patient failed an adequate trial with at least two (2) other different NSAIDs which is documented in their CHCS prescription profile?** If yes, please consider a trial of meloxicam (Mobic), a COX-1 sparing NSAID, which has demonstrated decreased incidence of GI side effects relative to traditional NSAIDs. ☐ Yes ☐ No
7. **Is this patient receiving drug therapy with oral or injectable corticosteroids, anticoagulants, or antiplatelet agents?** ☐ Yes ☐ No

If the answer to one or more of Questions 5, 6, or 7 is yes, benefit is approved for up to 1 year, depending on the number of refills prescribed. If not, benefit coverage is not approved.

Step 3 Please sign and date

_____ _____

Prescriber Signature Date

Latest revision: August 2004